

DELAWARE ELECTRONIC VISIT VERIFICATION (EVV) PROVIDER SURVEY SUMMARY OF RESPONSES

INTRODUCTION

The EVV provider survey was opened on November 5, 2018 and closed on November 27, 2018. The purpose of the survey was to share information on the State's proposed EVV design with providers that will be impacted by the EVV mandate. The survey sought feedback from all providers on proposed EVV design features as well as solicited information from providers who currently operate or are in the process of purchasing and/or implementing EVV systems. For this sub-set of providers, the survey sought information regarding providers experience with implementing their EVV systems as well as detail around features found within their specific systems.

SUMMARY RESULTS

Thirty-five surveys were initiated, with 22 complete after adjustments were made for duplicate and incomplete surveys. While duplicate surveys were removed from the responses, feedback from partially completed surveys was considered. Each question contains the number (n =) of completed surveys for any given question.

GENERAL OVERVIEW

Populations Served

The survey respondents included a broad spectrum of response from agencies serving members across all populations.

Number of Staff

The survey covered over 5,600 individual direct care and home health workers as well as an additional 1,729 staff that were identified as living in the home of the individual/member.

Counties Served

All counties within the State of Delaware were well represented by the providers responding to the survey with at least 20 providers indicating some service being provided in all three counties.

Current Technology Infrastructure

Over 40% of the providers indicated that they were currently using electronic health records, computers and tablets with internet access. Nearly half of the providers reported having IT support for their organizations. Based on this information, there may be challenges ahead for the EVV system implementation around the lack of technology capabilities/support with some providers.

PROVIDERS WITH EVV SYSTEMS

Twenty-eight providers responded to this question and 16 indicated operating or purchasing an EVV system. This number is significant because early indicators showed that not many providers had systems in place. Eleven of the 16 organizations who had or were purchasing systems consistently completed the entire survey. Only two EVV Vendors, Medsys (2) and Alora Health (3), were identified as being used by multiple providers.

Seven of the 11 providers implemented their systems in 2018. Three providers reported implementing systems in 2011, 2014 and 2017 while one is targeting implementation in 2019. Nine of the providers indicated that testing, training and piloting to “go live” took 120 days or less and most reported routine operation within 30 days of go live which indicates a better than average uptake of the technology by provider staff, individuals, members and families. Only one provider indicated that it took more than 120 to get to routine operation.

The cost of the implementing systems varied from \$0 to \$35,000 for initial startup costs. A small number of providers reported their average ongoing annual cost. These costs were around \$18,000 a year on average. These annual costs appear to be driven higher by the implementation of electronic health records in association with the EVV capabilities. The average annual cost per direct care worker/staff varied from \$68 to \$810 per year. All of the providers reported better than average experiences with implementation, training and adoption of the systems. The highest weighted average – on a scale where 1 = Poor and 5 = Excellent – was for administrative staff adoption (4.1) and the lowest was direct care worker/staff adoption (3.4).

While a range of accessibility features were identified by a few providers, a majority (8) indicated that they had no features to accommodate people with hearing, physical or other impairments. With the exception of one provider who indicated that their EVV system cannot currently track “type of service”, all of the responses indicated that the system could meet the requirements of the 21st Century Cures Act. Rural and technology based barriers were identified and are mainly being managed through telephony (use of landlines) or paper timesheets.

As a result of this survey, DMMA now has insight into the types of data collection methods as well as system capabilities that are important to providers as well as the training approaches employed. Results around training did indicate that providers who have systems in place did not focus on system training for members.

PROVIDERS WITHOUT SYSTEMS

When looking at the strength of weighted responses, providers indicated a desire for global positioning system (GPS) capabilities when considering the data collection capabilities of the system. Both providers with and without systems had varied responses to current visit verification practices, i.e., verification at the start and end of the shifts. This information provides insight in to the approaches that can be considered by DMMA moving forward.

The ranking of approaches to training administrative and direct care workers/staff closely followed the approaches taken by providers that already had systems in place. Ratings for the approaches to training for administrative staff and direct care workers/staff were closely aligned. For individuals the training based on the type of service being provided and a 1:1 approach were highest rated followed by on-line interactive training. Webinar based trainings were least preferred among all the training options for these providers.

INITIAL PROPOSED DESIGN ELEMENTS

Support for the various design elements varied from a low of 55% for tracking direct care worker qualifications to a high of 91% for making sure the system has an exceptions process. Below is a list of proposed design elements with a discussion of the reasons provided by providers about why they may or may not support a particular design element.

- One state-wide EVV system for data collection and data aggregation. This would allow other systems currently operating to continue to be used. **73% Support**

Discussion: A provider suggested that each agency should be able to pick the solution that best fits their processes and more than one indicated that they wanted to continue to use their current systems.

- Member and direct care worker will verify services at the end of every shift/visit. **86% Support**

Discussion: One provider questions the ability of the individual or member to verify services and therefore did not support this design element.

- System will include a list of tasks from which the direct care worker can select during each shift. **86% Support**

Discussion: The only comment regarding this design element was stated as support, as the providers EVV system had a similar capability.

- System will include an "exceptions" process that permits providers to correct errors/mistakes within state prescribed timeframes. **91% Support**

Discussion: One provider expressed concern about the exceptions process impacting his current system operation and requiring an additional build-out of their current EVV software. There was concern expressed regarding self-directed services and the correction of the verification of services without a supplemental system in place based on Medicaid and DOL standards.

- The system will include functionality that allows for a member/family portal for verification of services, comments and general review of EVV data and information. **68% Support**

Discussion: Providers indicated that the comments section should be limited to comments related directly to services rendered. The concern is that the comments section would be used for other purposes such as complaints and scheduling request and thus overwhelm system. Another

provider expressed concern that a member portal requirement would impact the current operation of their system which would have to be modified to accommodate this function. Others suggested tight controls for a member/family portal should be maintained.

- The system will include reporting and dashboard functionality at various user levels (State, MCO, provider). **82% Support**

Discussion: One provider wanted more specifics on the dashboards. Some were concerned that state-level interfaces that tie to the provider's EVV interface could add complexity to provider billing and client care. Alabama's model is an example of this complexity.

- Some quality of service information may be captured. **73% Support**

Discussion: Providers requested more specifics about what might be measured and again expressed a concern that existing systems may not have this capability and would require modification.

- System may generate unique direct care worker identifier allowing direct care worker's to be tracked across providers. **59% Support**

Discussion: Providers expressed concern about the usefulness of this feature and wanted more information before they could support this proposed design element. One provider did not feel that direct care worker identifiers should be tracked and that data collection should be focused on client based information including plans of care. Some providers expressed concern that this information could be used by providers to "steal" direct care workers from one another. The need for staff to have yet another ID to remember was a concern as well.

- System may have the ability to track direct care worker qualifications. **55% Support**

Discussion: Providers indicated that qualifications should only be available to providers who employ or are hiring direct care worker and inclusion of this information may require modification of existing system. Also concern about how this might work in self-directed model.

GENERAL COMMENTS

The survey concluded with an open ended request for input from providers regarding any of the design elements. Providers offered assistance to DMMA around this effort. One provider suggested that more stakeholders should be involved in the selection of the EVV system in Delaware. Another touched on the need for not only direct care workers and member verification of visits, but also the need to accommodate verification by a representative. They also suggested that verification of services not provided during a "home visit" should be accommodated.

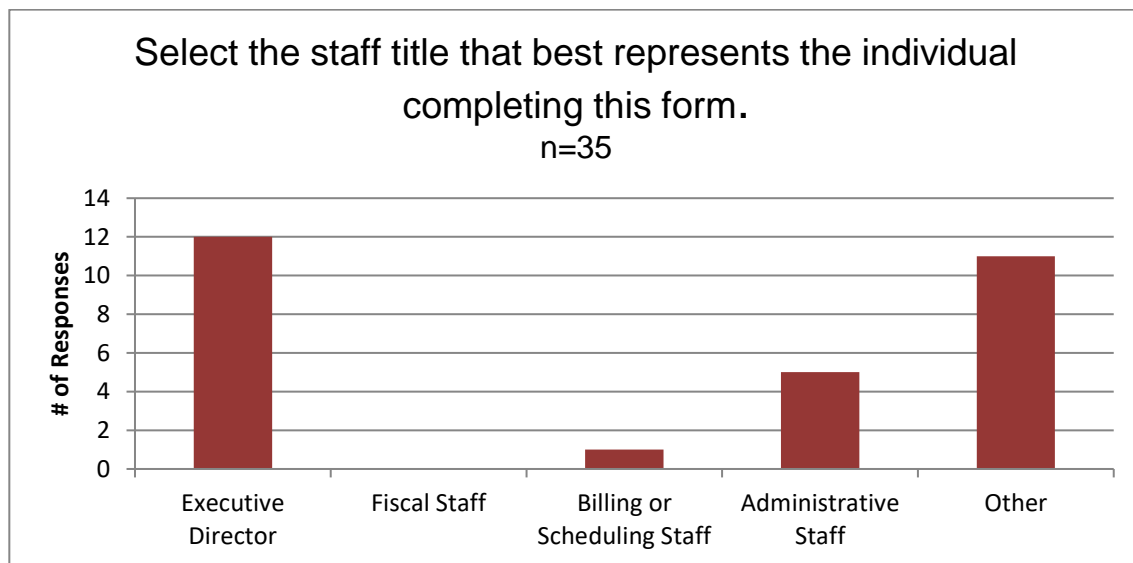
Providers also made suggestions regarding operational capabilities of the system including the need for access through mobile devices and functionality for "mid-shift check ins" or "random check ins" that should be available to providers to ensure aides are staying entire shifts. There was also concern expressed regarding the GPS schedule location. The EVV system should have both a Scheduled Start GPS location and a Scheduled End GPS location, i.e., an alternative service location for movement during service delivery. Mismatched GPS Locations due to these movements can be an issue in other EVV systems. The respondent went on to suggest that EVV service location should allow for a 1/2-mile variance to greatly reduce EVV data errors due to mismatching GPS location errors.

Recommendations of a technical nature included requests that an 835 Claims Payment Advice transaction set, 277 Claims Status Response and 999 transaction capabilities be included as part of the system requirements. It was also suggested that a claims tracking ID number be part of the EVV file, even if the EVV Vendor creates the claims, so that Providers can reconcile claims if using an alternative EVV Vendor.

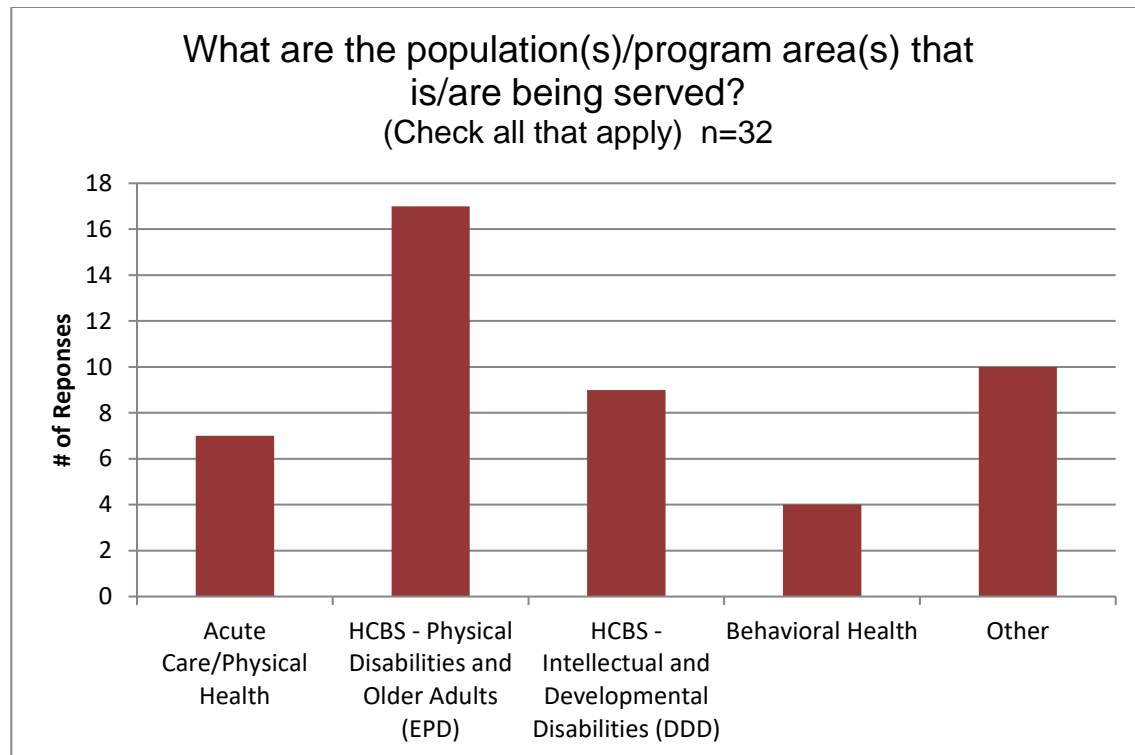
Finally, some providers expressed concerned that if certain elements of the state system were adopted like the collecting a direct care worker signature (electronic or fingerprint), that it might require their vendor to build-out software in order to be compliant. Most states accept a login ID and a password.

OVERVIEW OF RESPONSES

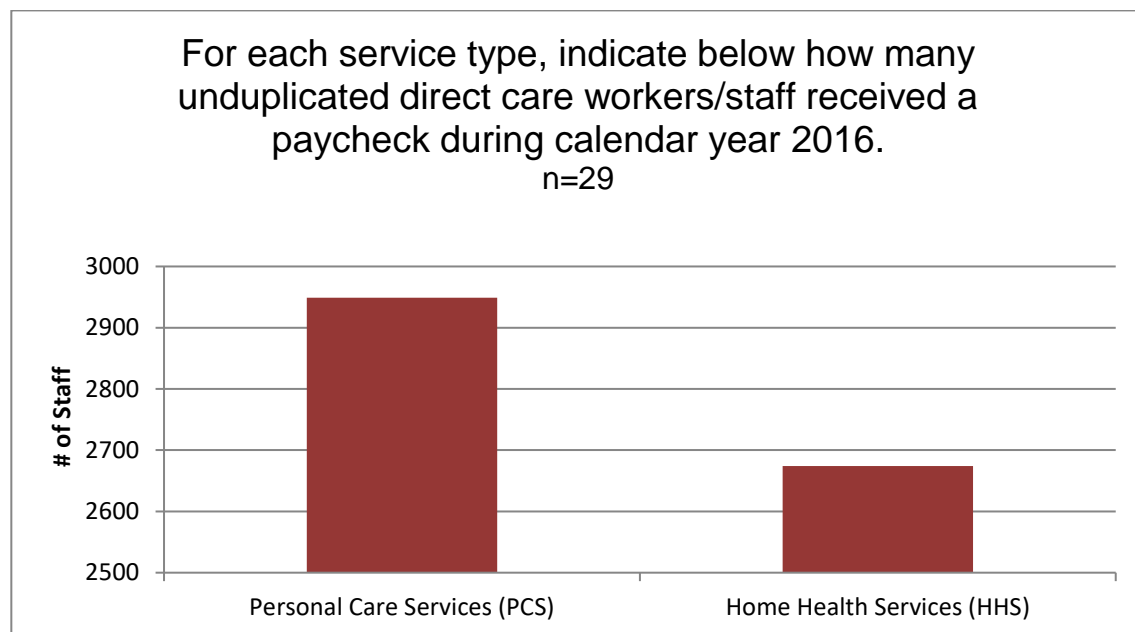
Initiated Survey:	35
Duplicate Survey:	03
Partially Completed:	12
Complete Unduplicated Total:	22

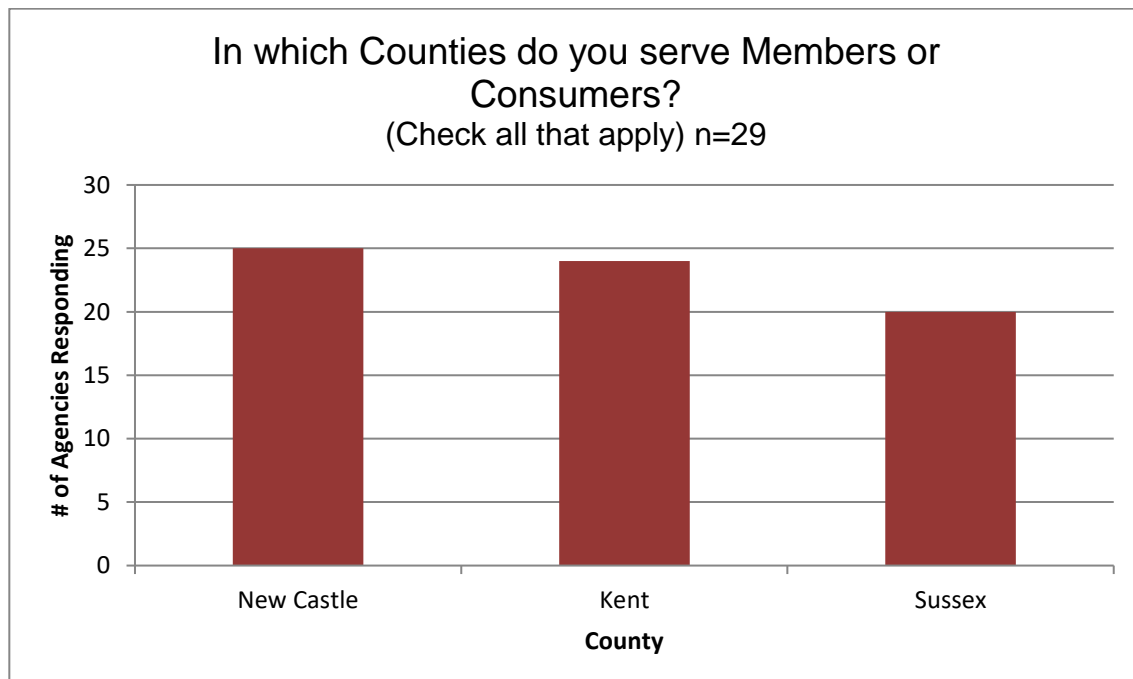
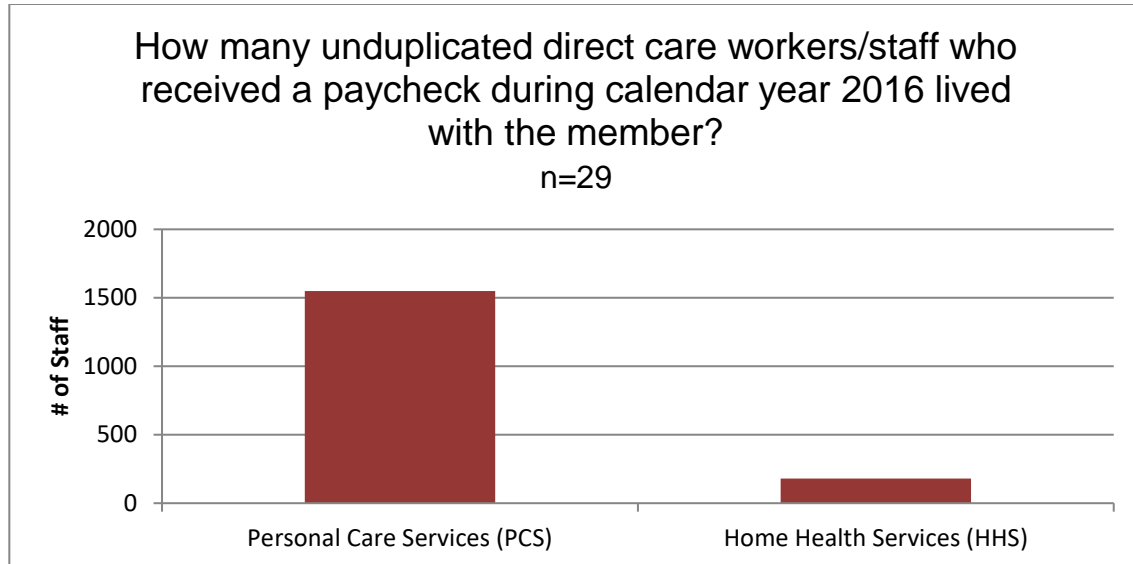


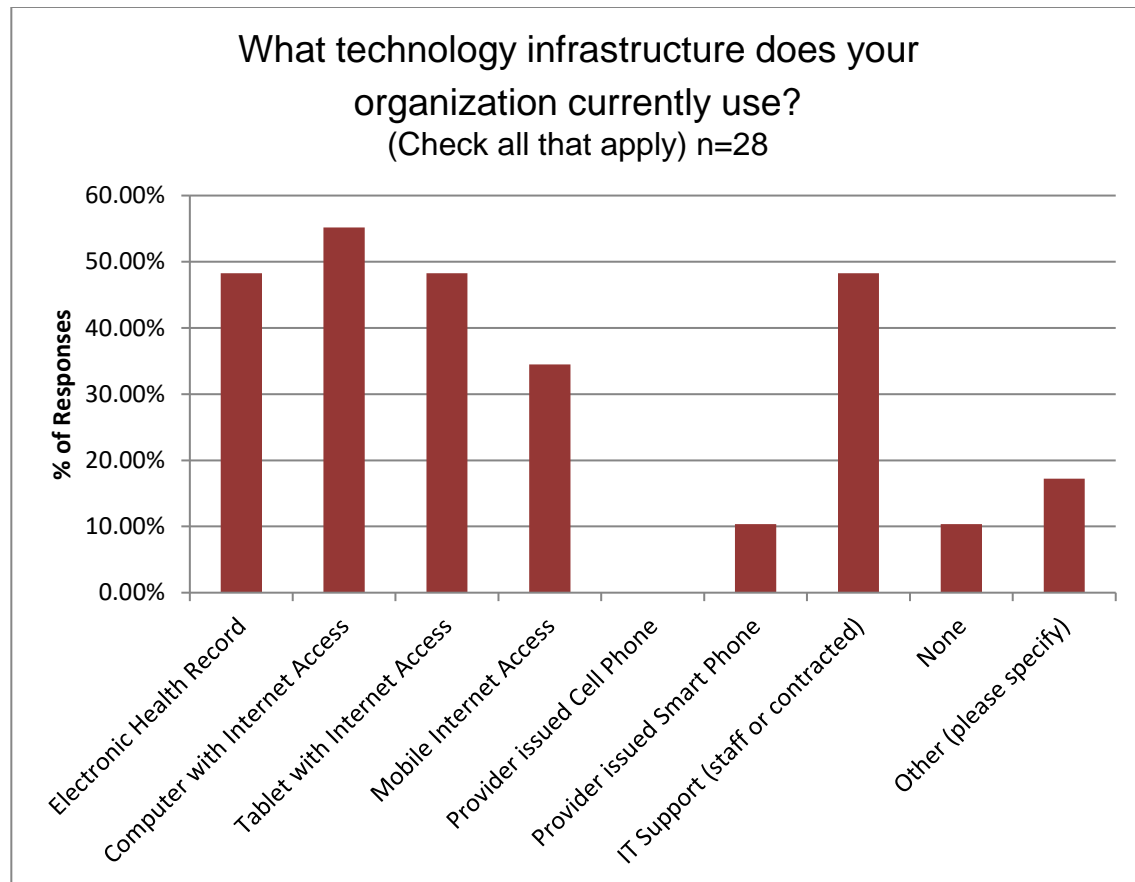
Other: Program Directors, Program Coordinators, Operations Directors and unidentified titles.



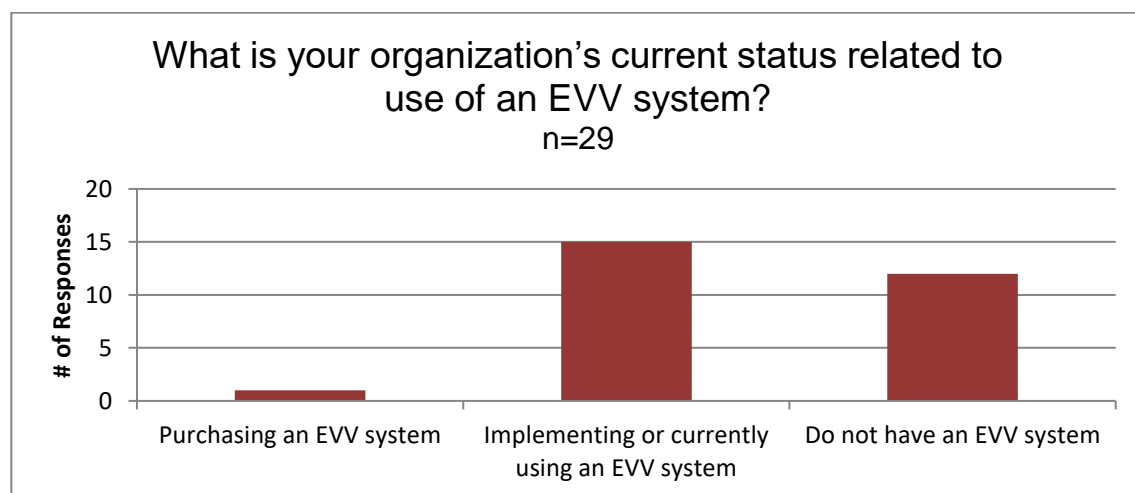
Other: Pediatric, Early Intervention, Private Duty Nursing, Skilled Nursing Visits, Billing Agent and EVV Vendor

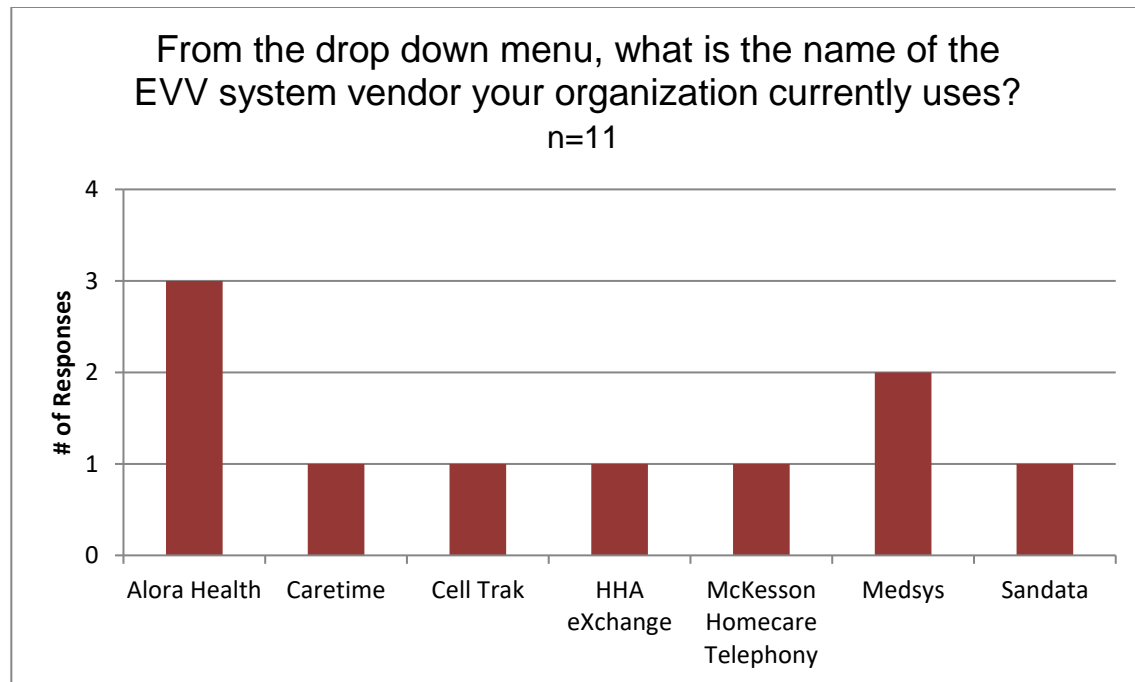




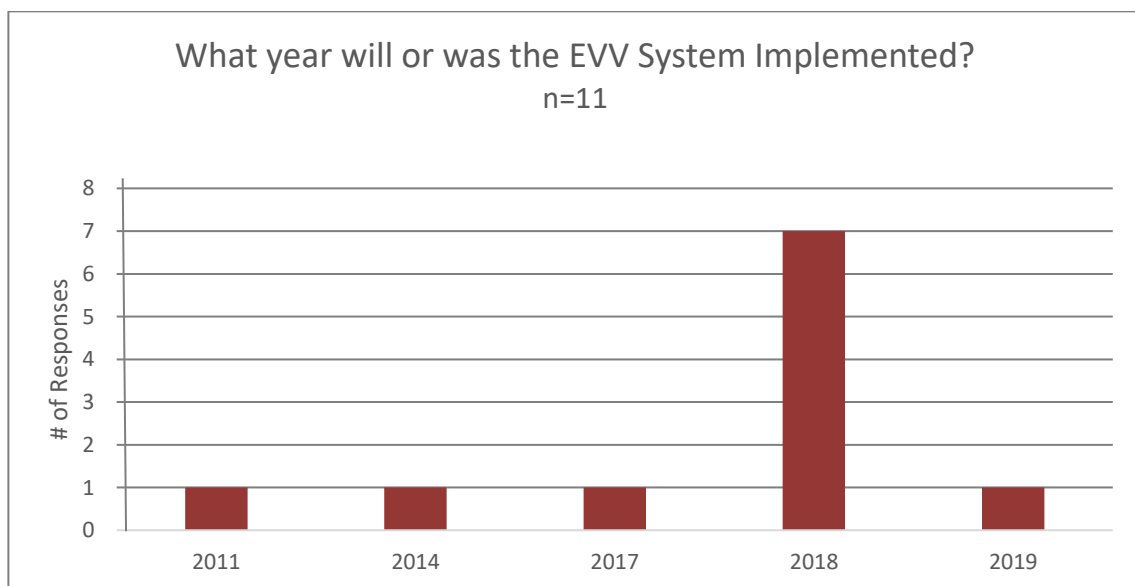


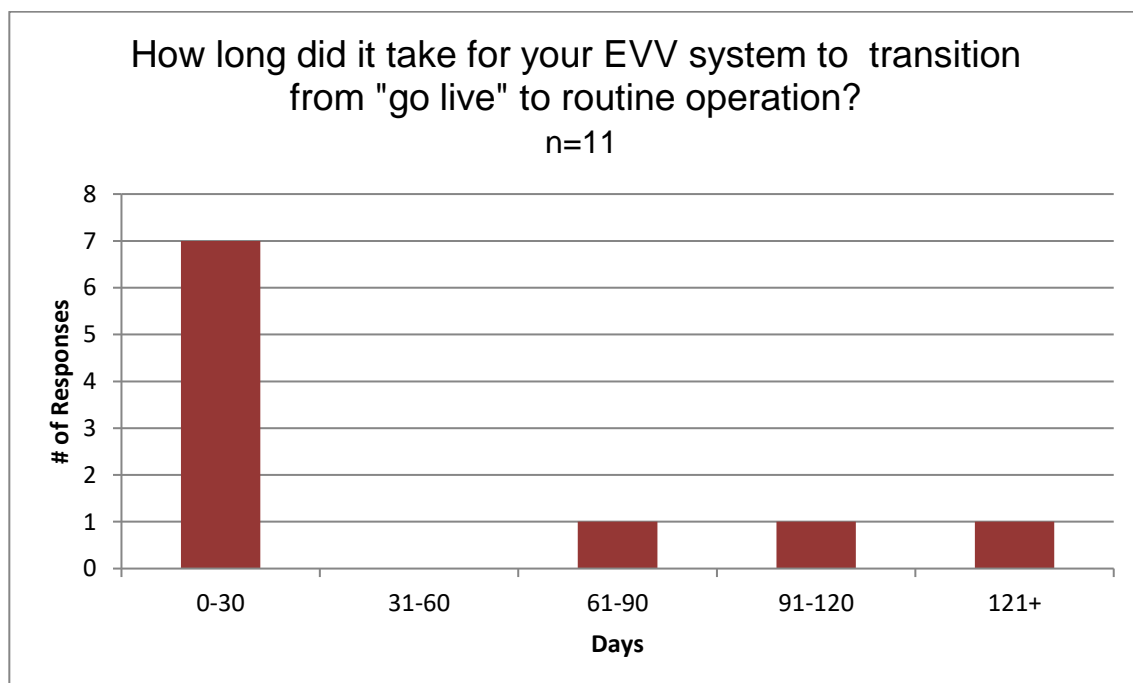
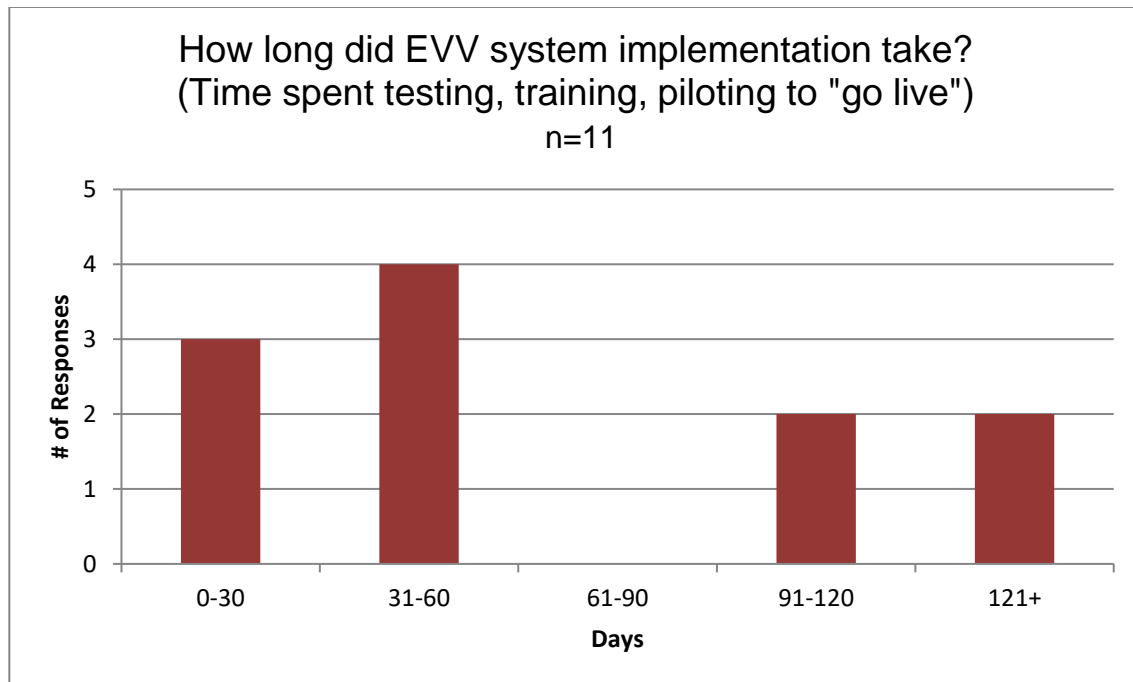
Other: Organizations identified using EVV applications and one mentioned using paper for only skilled nursing visits.



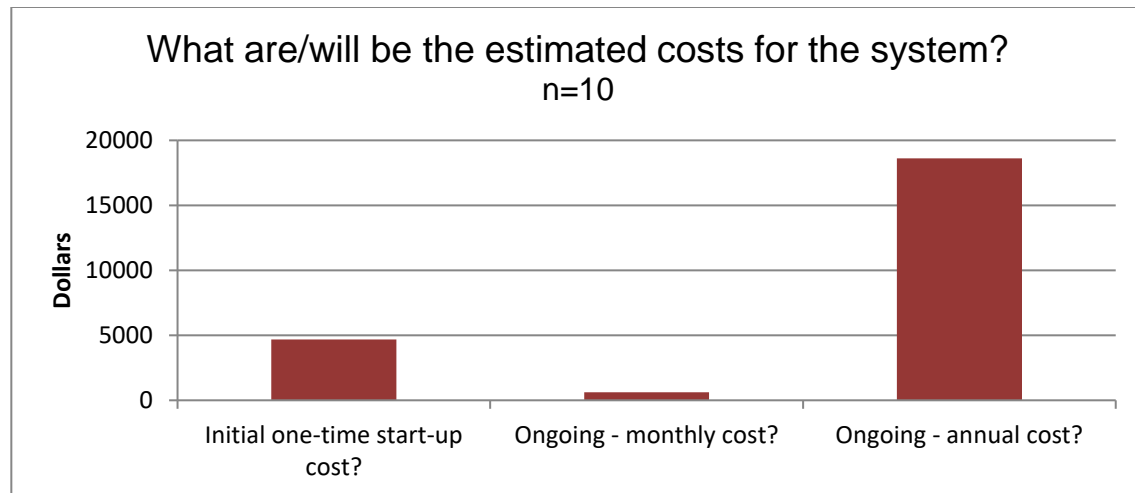


Other: Lack of an “other” option listed in the drop down created confusion over this question. It appears that providers may have selected a provider from the dropdown and reported a different vendor in the comment box provided. Other systems identified that were not on the dropdown list included Therap, ClearCare, Celayix, MaximCare Mobile, Delmarva Digital, Clare Care, Kinnser, KANTIME.

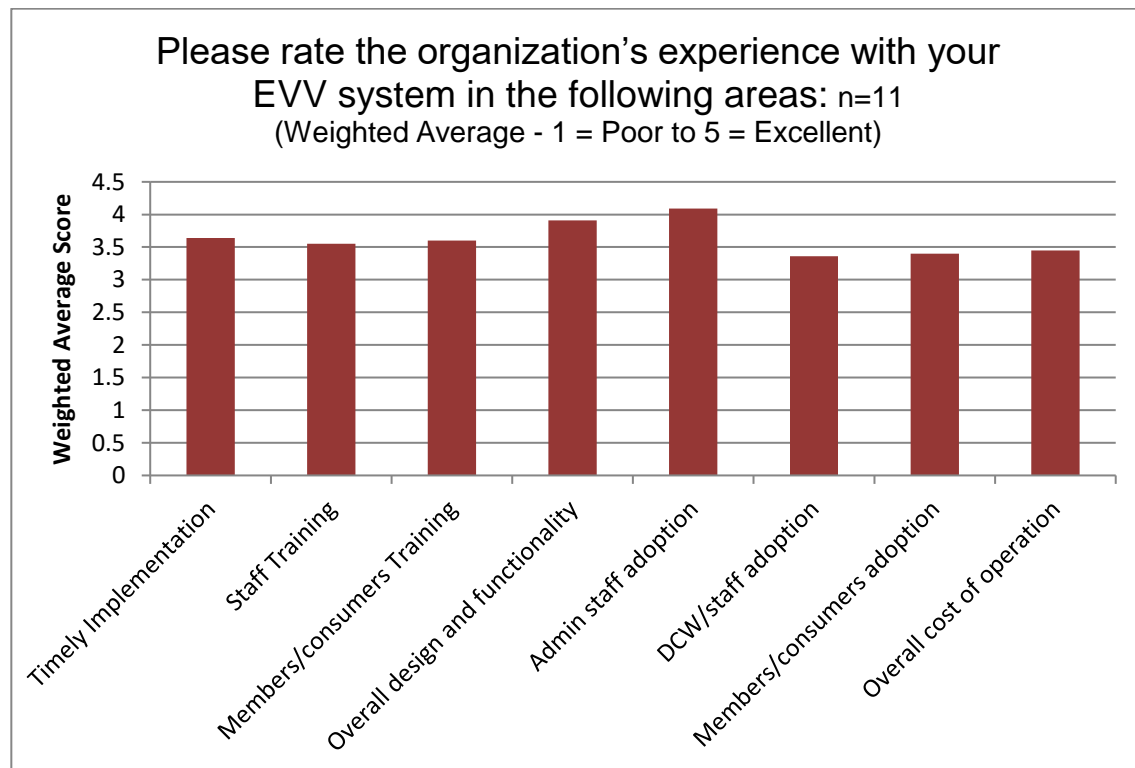




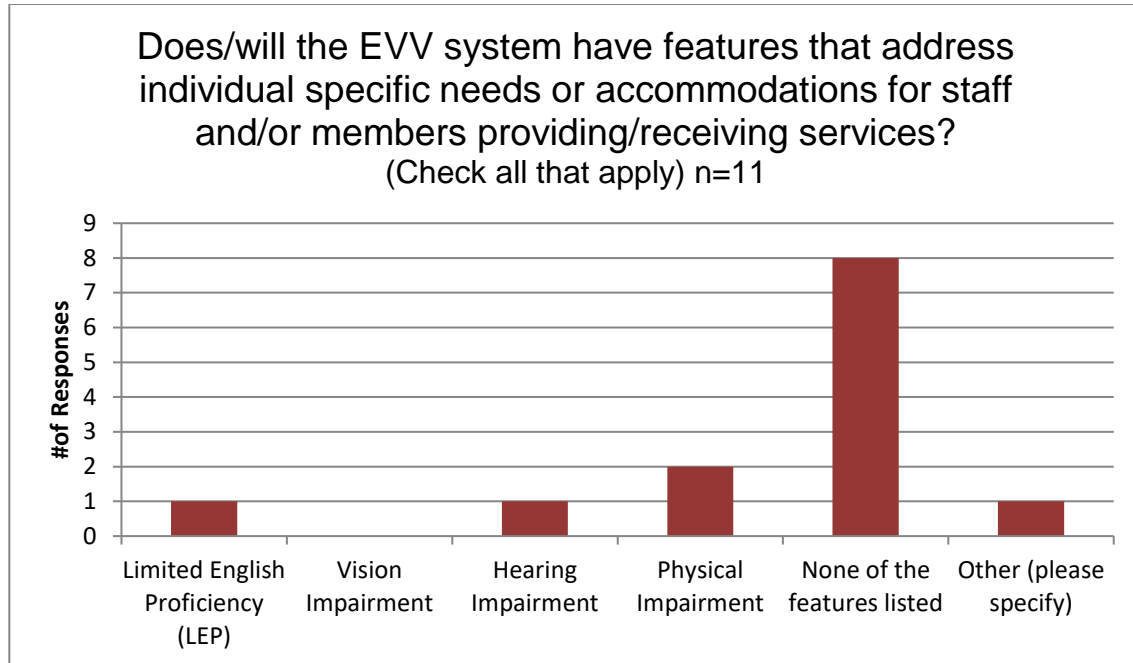
Other: One response indicated "currently processing".



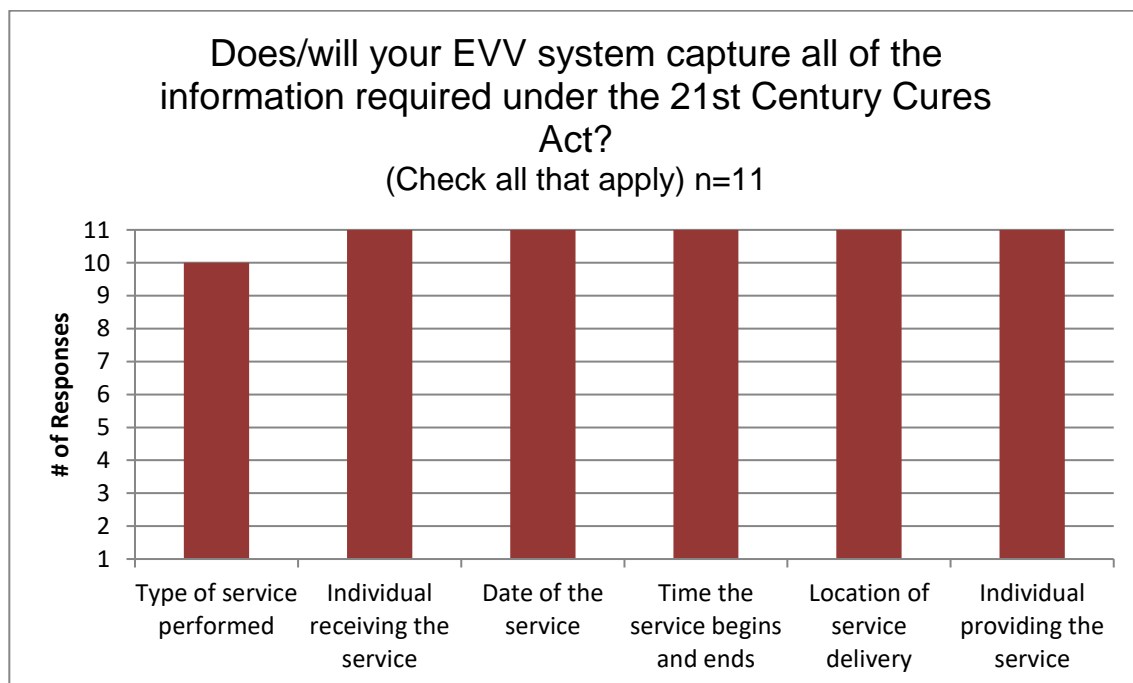
Other: Initial one-time costs varied from \$0-\$35,000+, ongoing - monthly cost varied from \$0-\$2,000 and ongoing - annual cost varied from \$0 - \$100,000.



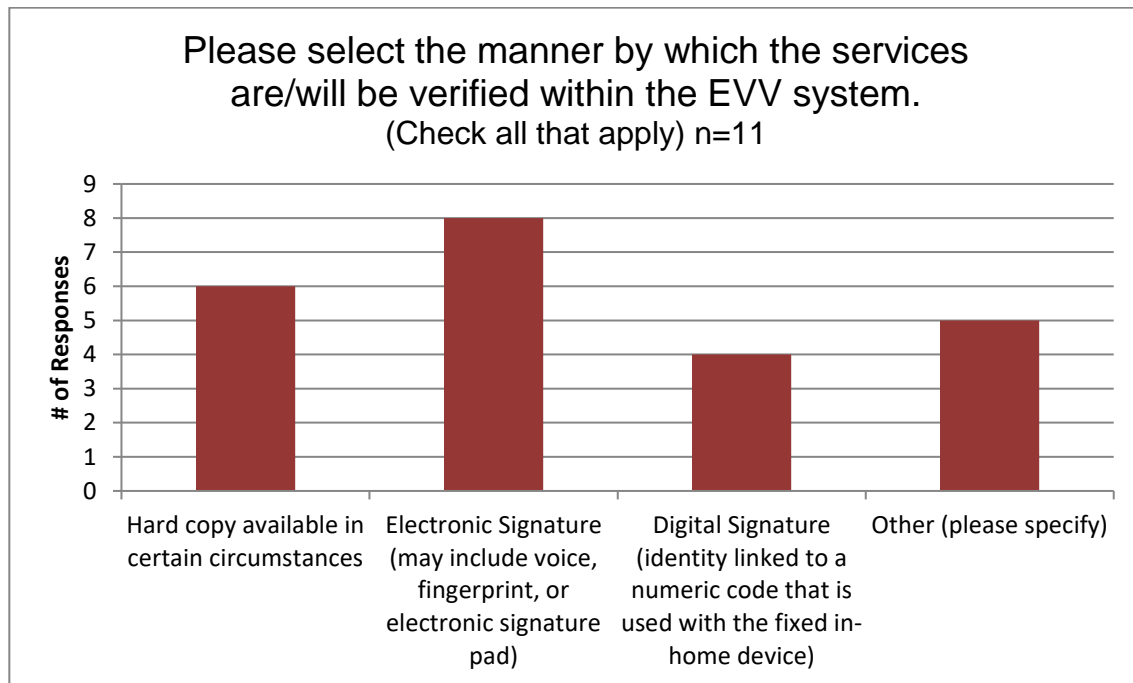
Other: One agency reported using telephony still, another recommended using GPS, another indicated that Sussex County has little cell coverage and finally one indicated that the technical assistance provided by the EVV vendor was excellent.



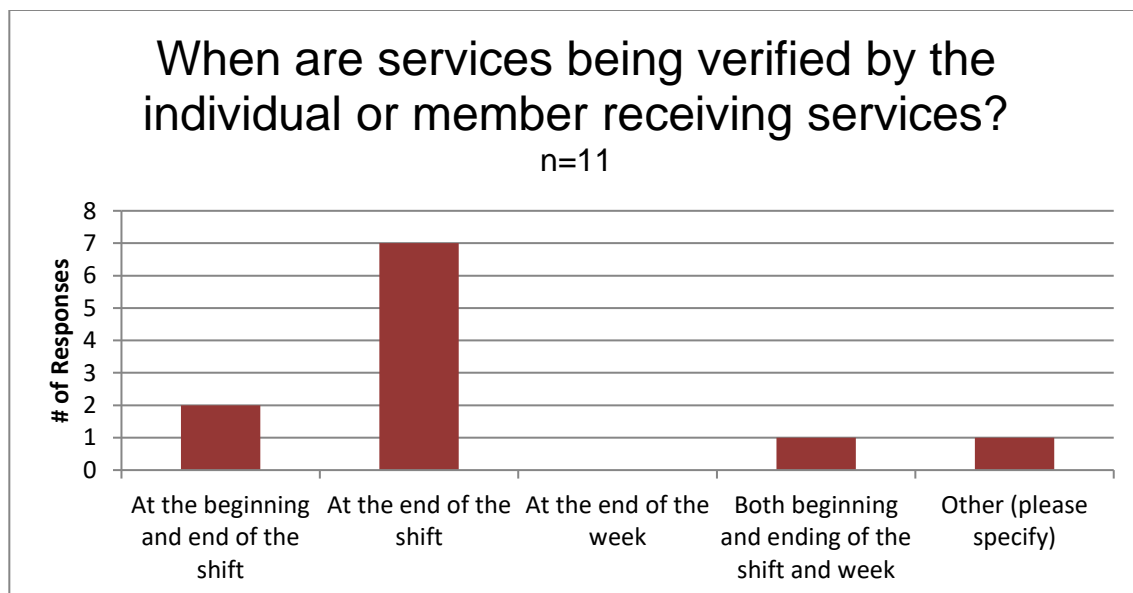
Other: iPad has accessibility features.



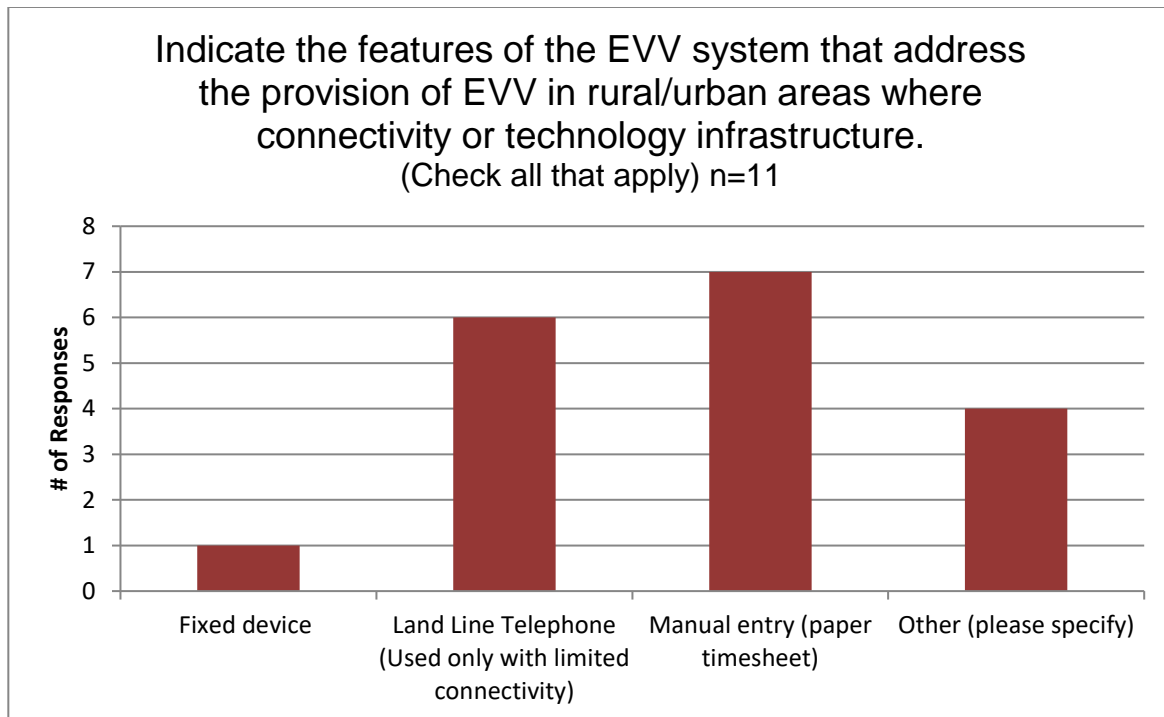
Other: One provider reported that there will be no cost for adding the "type of service performed" functionality by Q2 2019



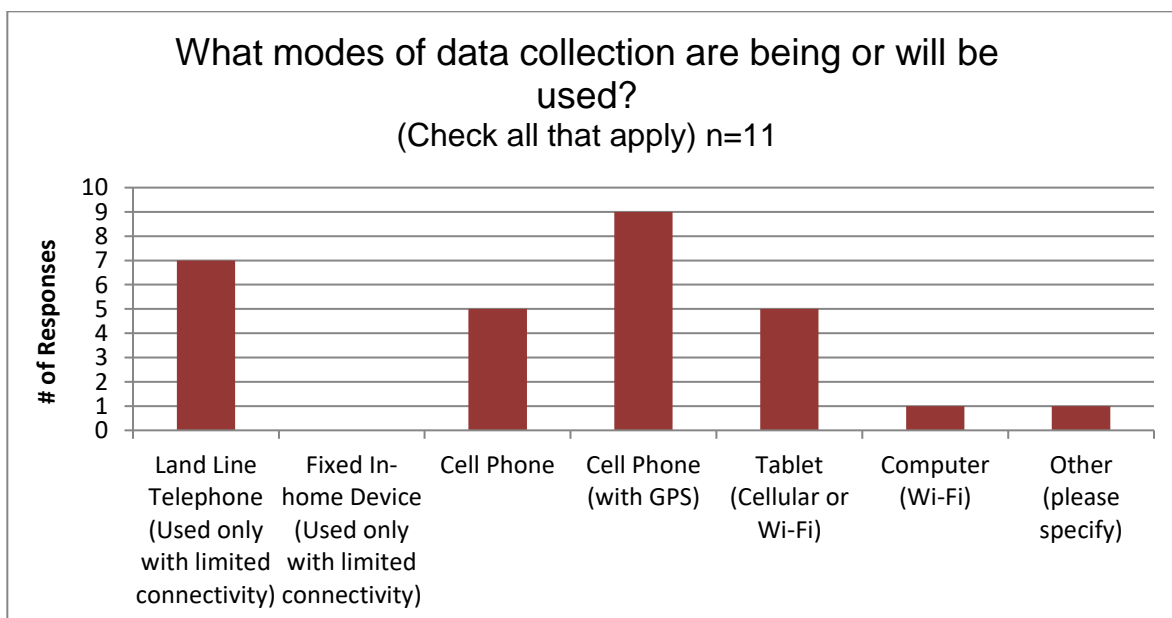
Other: Voice recognition, individual/member electronic signature box, not yet finalized and GPS signal for location of service.



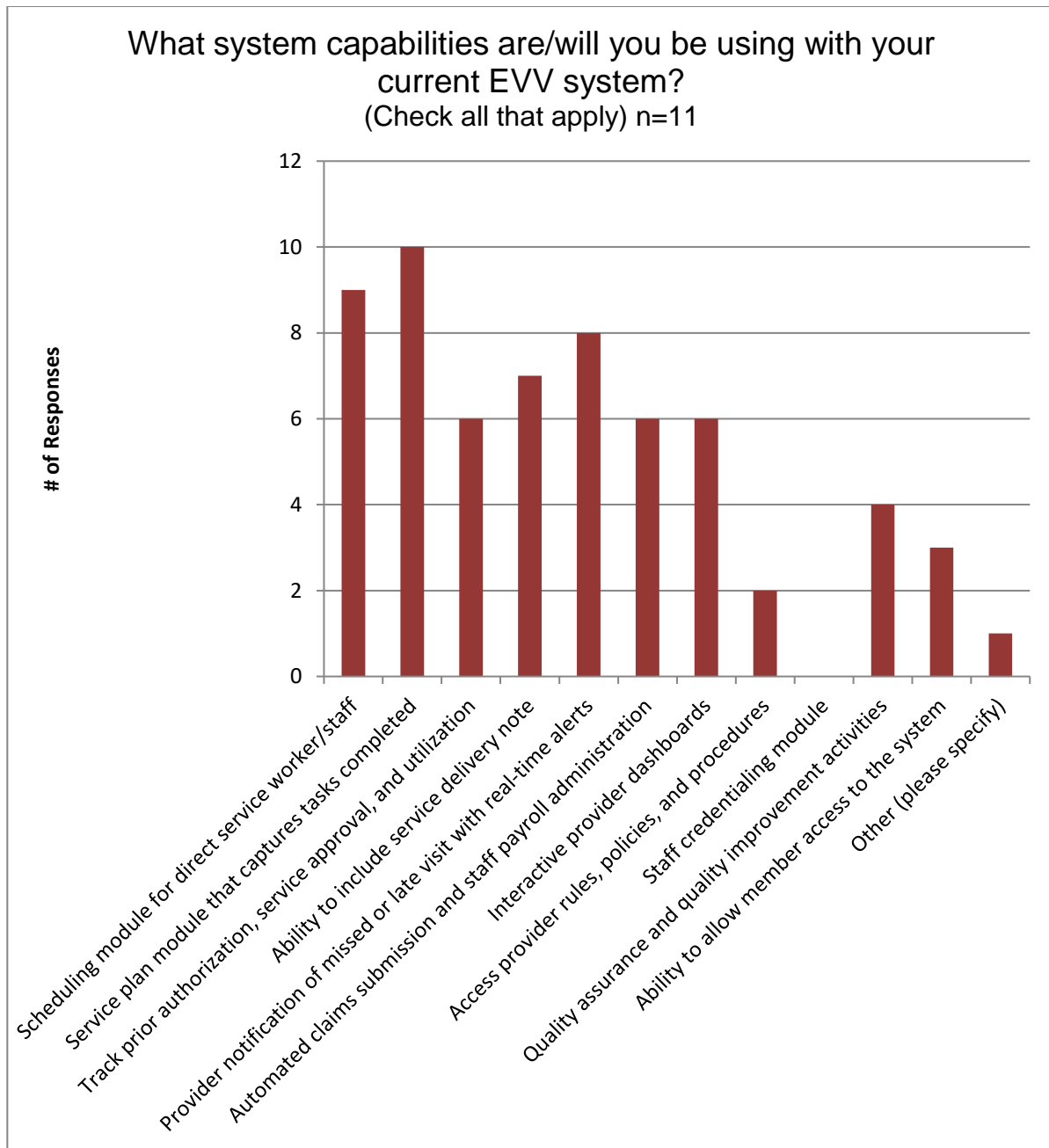
Other: During reported intermittent visit time.



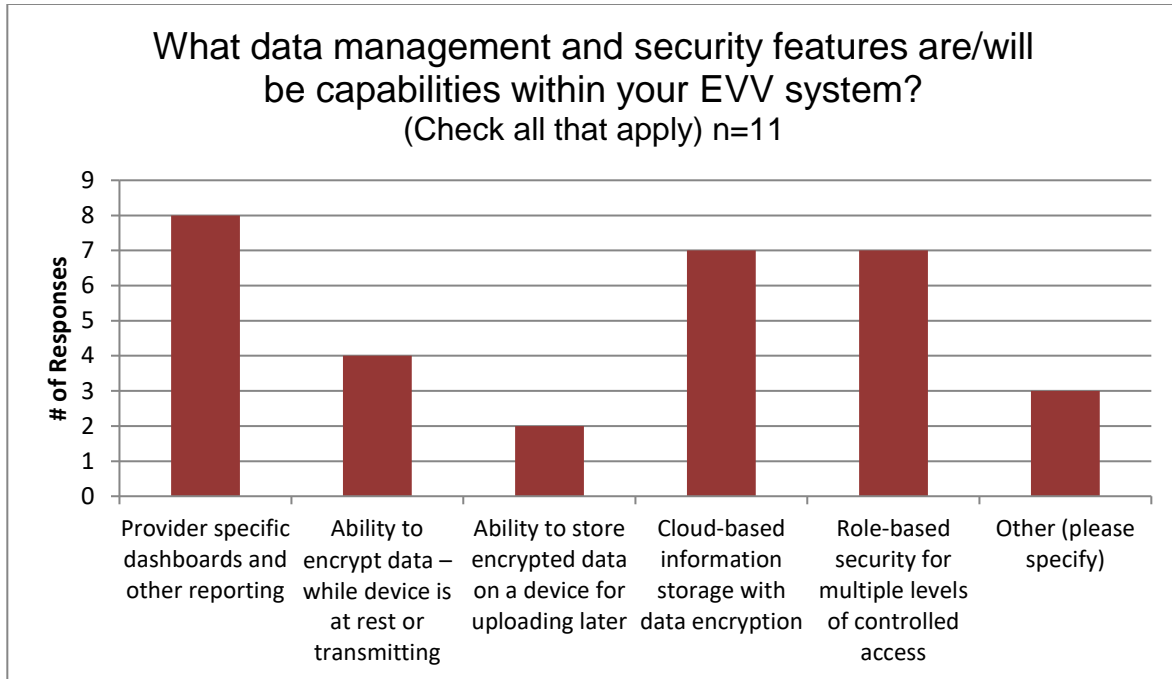
Other: Voice recognition [land-line], paper visit attestation, captures information in a disconnected state, and unknown.



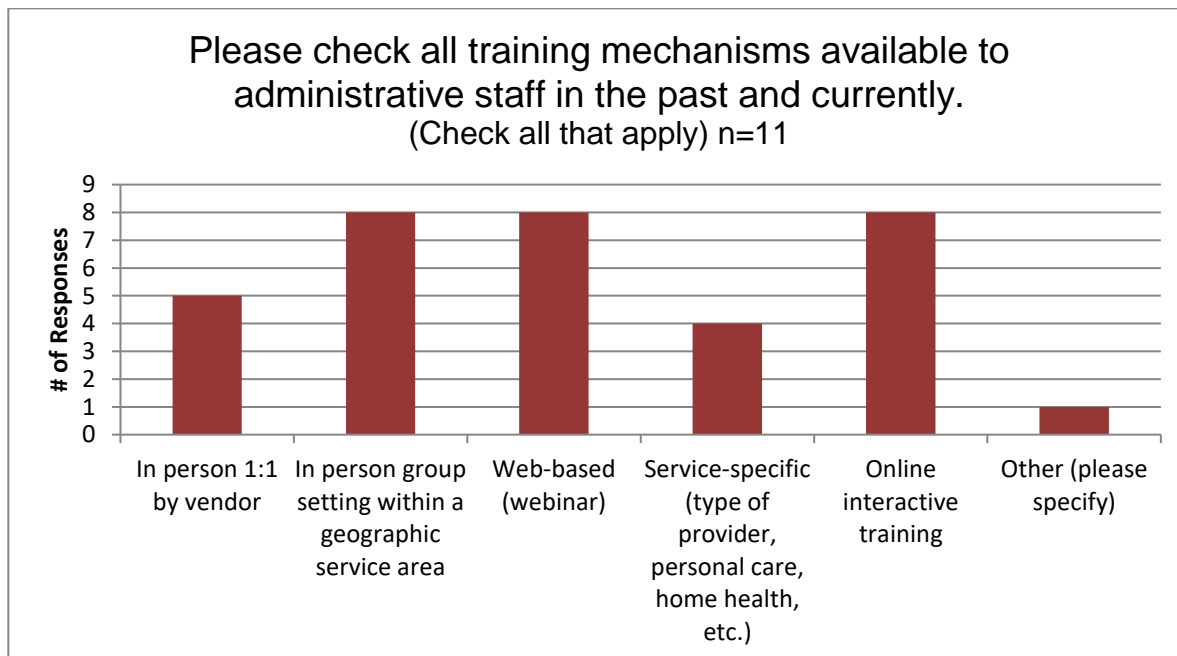
Other: Voice recognition.



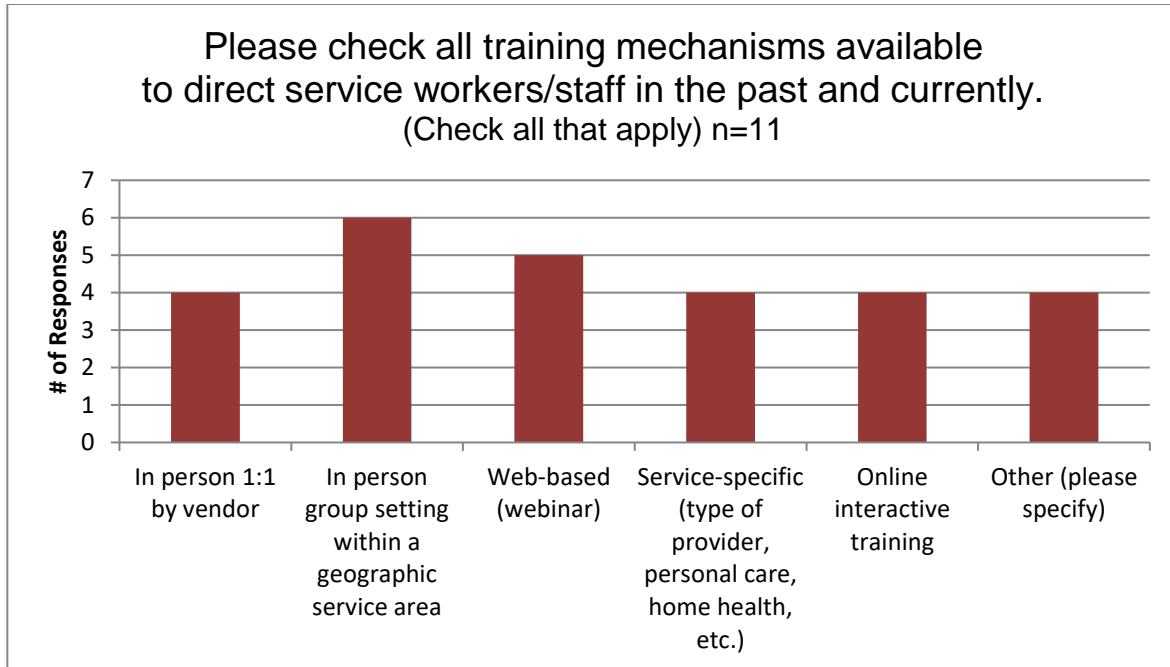
Other: EVV is part of EMR.



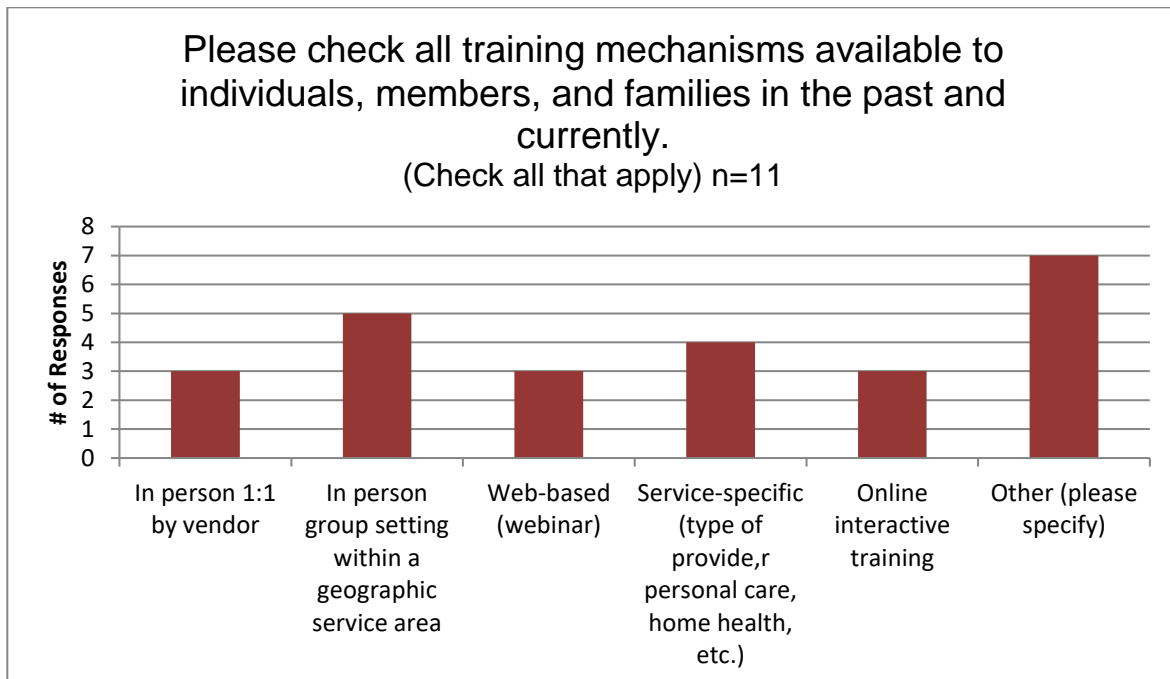
Other: Direct submission of claims to electronic data interchange - MMIS vendors, secure server with data encryption, and automatic lock out after 5 min not in use.



Other: Provider manual emailed upon request.

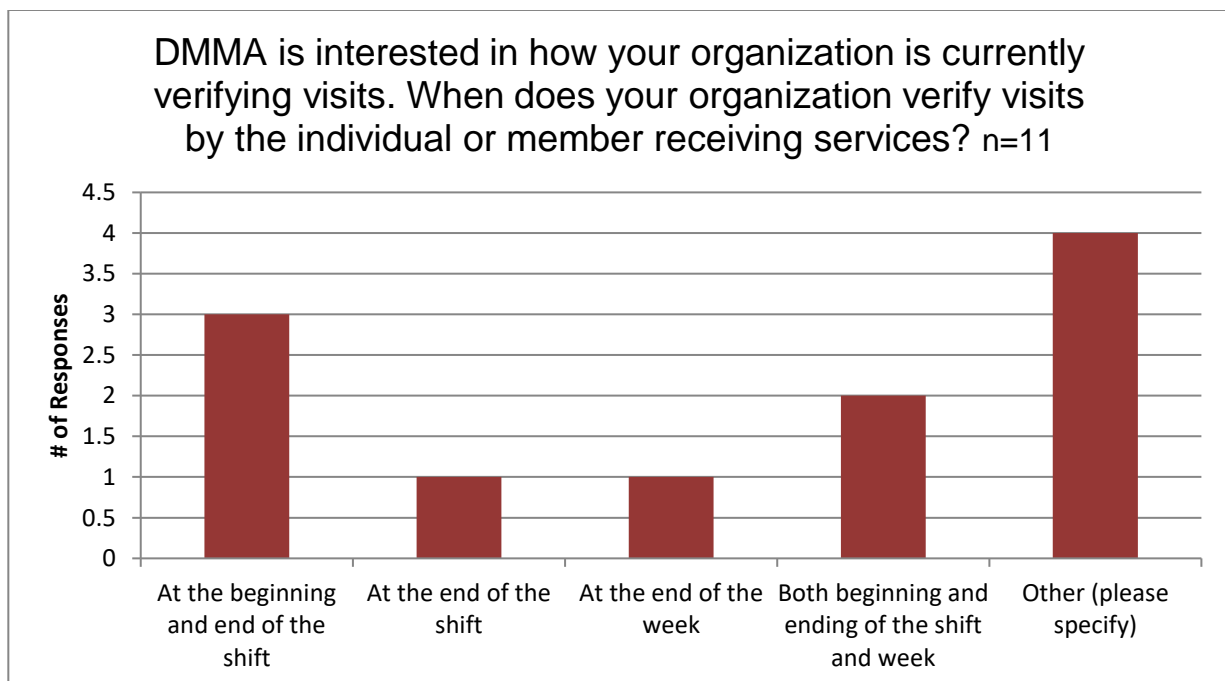
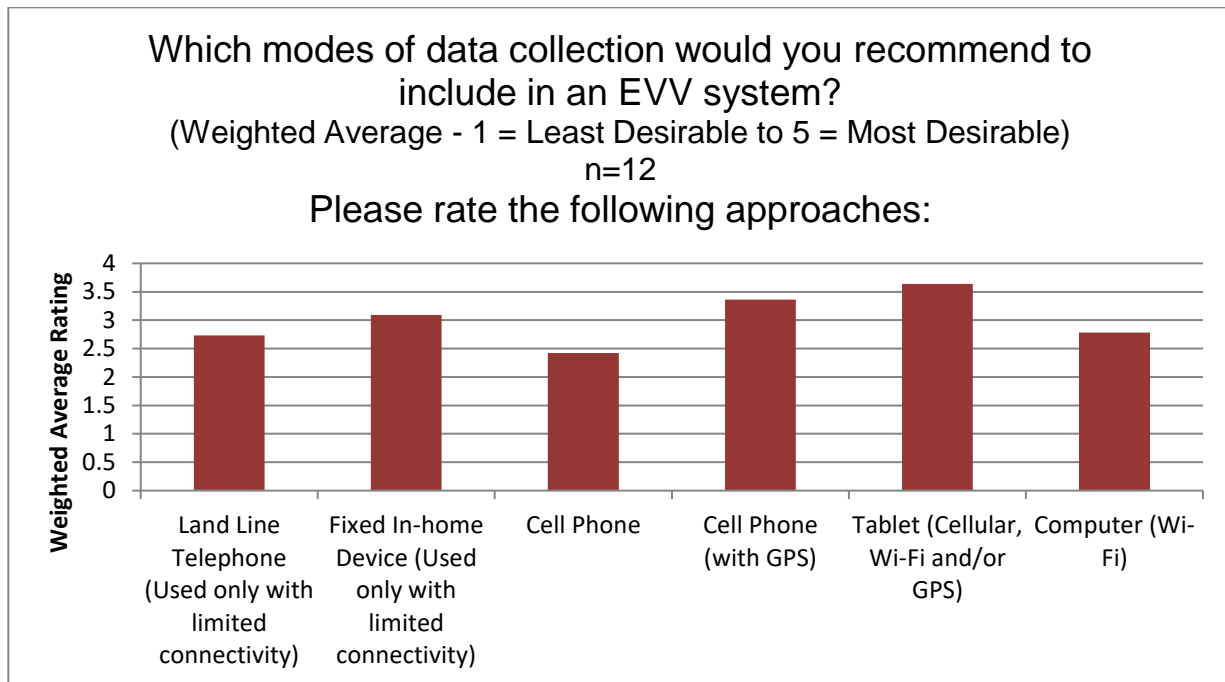


Other: Staff orientation, staff to staff, instructions available via email, and YouTube type instructional videos.



Other: Upon admission, by staff, none and YouTube like job aids.

Responses from Providers without EVV systems:

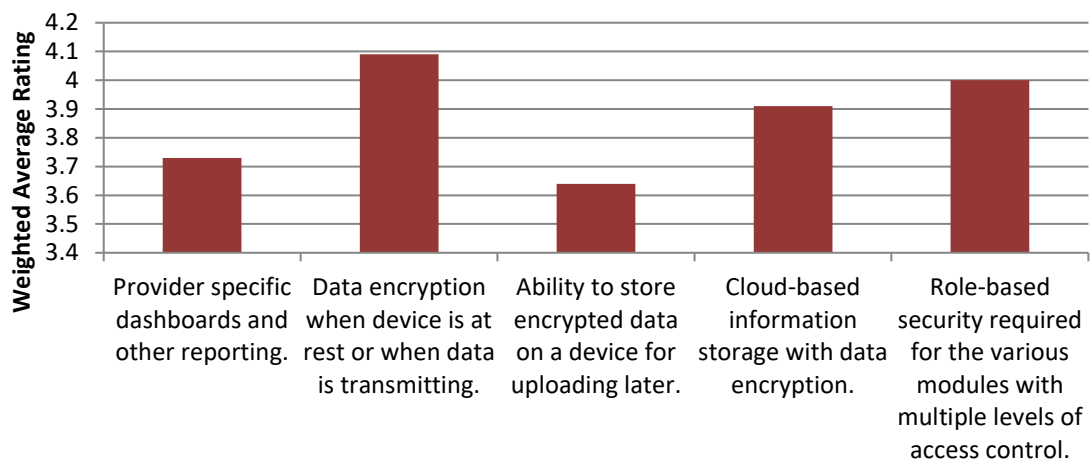


Other: Varies by billing document signed, all consumers attend day program and not applicable.

What features of the EVV system do you think might be important to providers with and without EVV systems? n= 11

(Weighted Average - 1 = Least Important to 5 = Most Important)

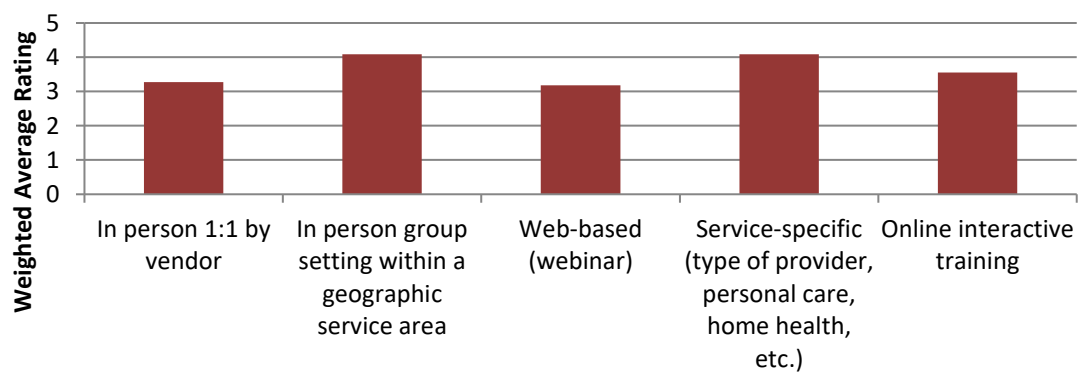
Please rate the following:



Provider administrative staff will require training on the EVV system. What are the preferred modes for administrative staff training on EVV system requirements and use? n=11

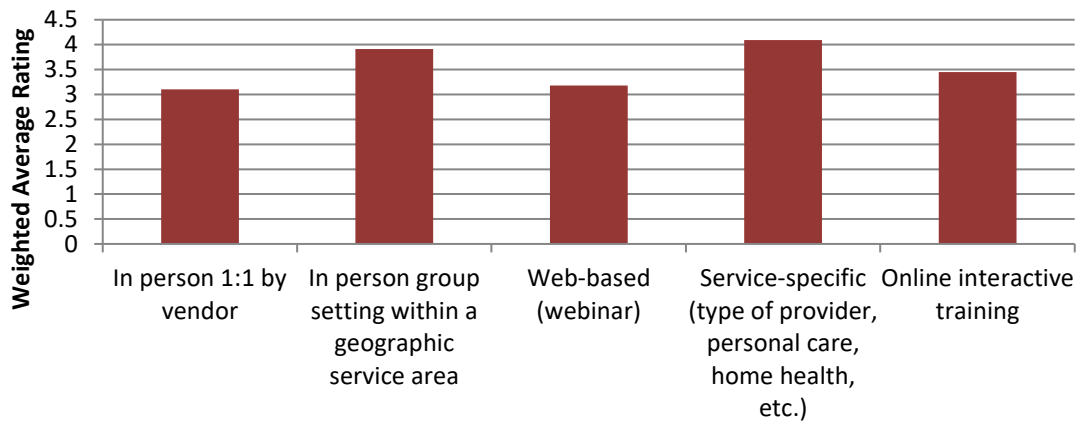
(Weighted Average - 1 = Least Desirable to 5 = Most Desirable)

Please rate the f



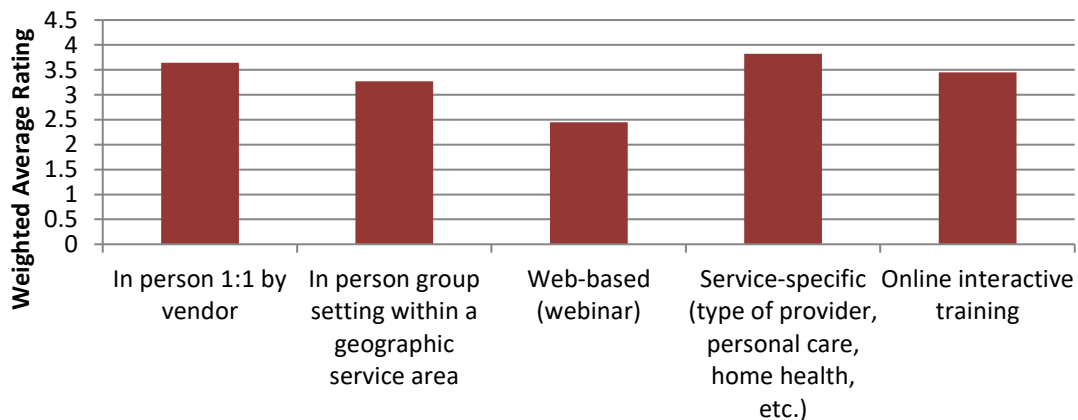
Provider direct service workers/staff will require training on the EVV system. What are the preferred modes for direct service workers/staff training on EVV system requirements and use? n=11

(Weighted Average - 1 = Least Desirable to 5 = Most Desirable)



Individuals, members and families will require training on the EVV system. What are the preferred modes for Individuals, members and families training on EVV system requirements and use? n=11

(Weighted Average - 1 = Least Desirable to 5 = Most Desirable)



DELAWARE ELECTRONIC VISIT VERIFICATION (EVV) PROVIDER SURVEY RESPONSES

